Medwork Independent Review
2777 Irving Blvd, Ste 208
Dallas, TX 75207-2309
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
Independent.Review@medworkiro.com
www.medwork.org

Date: July 21, 2015

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: 7/21/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Right wrist surgery, arthroscopy, excision and/or repair of triangular fibrocartilage and/or joint, synovectomy, distal radioulnar joint repair of triangular fibrocartilage complex.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed MD Board Orthopedic Surgeon

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)
Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY:
The claimant complained of pain in the right wrist, which developed in xx/xx while he was moving a cable. He states that he twisted the wrist and also states that he had triquetral ligament tear. The claimant complained of numbness and tingling and the impression, that his physician has, is that he has concern for a capsular tear. The physician reviewed prior MRI results and was concerned about a capsular tear. The claimant had a positive Watson. The physician recommended an arthroscopy with abovementioned surgery with management of his pain.

Illegible date, MRI arthrogram of wrist was noted. The MRI of the right wrist concludes that the triangular fibrocartilage is intact. Lunotriquetral ligament tear normal alignment.

Clinic note from 03/24/2015 states that the claimant's symptoms have improved, but there are complaints of clicking and pain in the wrist. The surgeon concludes that there is no objective evidence for a surgical indication and therefore recommends to continue work without restriction. On 03/17/2015, the claimant continues to complain of pain in the wrist. A physician concludes that the claimant should attempt occupational therapy and continue with splint for an additional 3 weeks.

Medwork Independent Review
2777 Irving Blvd, Ste 208
Dallas, TX 75207-2309
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
Independent.Review@medworkiro.com
www.medwork.org

This initial consultation with the claimant states the assessment is that the claimant has a right wrist strain, but the MRI was normal and to attempt hand therapy. Progress note on 02/17/2015 concludes that the claimant has a right wrist sprain and referred him to another physician.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The claimant has established cordiality due to injury of the right wrist based on the mechanism of injury. The MRI did not identify the injury for triangular fibrocartilage and distal radioulnar joint was stable on clinical exam. Based on these findings, clear surgical indications have not been established in the medical documentation. Therefore, the requested surgery is uncertified.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

REFERENCES:

1. Green's Textbook of Hand Surgery and Official Disability Guideline (ODG).